Working with personality disorders

ASSIGN BUSTER

Literature review on the qualities needed to work effectively with a personality disordered population

Purpose of the literature review

I have been commissioned to complete a piece of consultancy work related to the recruitment of new discipline staff to the X unit Personality Disorder Treatment Service. Specifically, I have been asked to evaluate the existing interview and selection process and suggest ways in which this process could be improved. Part of this process involves designing a new recruitment process which adequately assesses whether candidates possess the necessary qualities to work effectively with personality disordered offenders. Literature related to consultancy suggests that anyone acting in a consultancy role should possess " expert knowledge" of the area in which they are providing consultancy. Although I have 9 years of experience working on the X unit, and therefore feel I have a good understanding of the ethos of the unit, and the type of staff who work well on the unit, I intend to revisit some of the literature relating to the development of personality disorder services, as well literature relating to effective working with personality disordered offenders. I will then use this to inform the process of developing a new, more effective way of identifying suitable new staff to work on the unit.

Early days of personality disorder treatment

The issue of how to protect the public from those who pose them a risk as a result of a severe personality disorder has long been a contentious one. The issue first gained public attention following Michael Stone's conviction in

1998 for the murder of Lin and Megan Russell. Following this awareness was raised of the need to provide treatment for psychopathic and personality disordered offenders, with a view to ultimately reducing re-offending within this population. In 2001, The Government made a pledge to provide more places in high secure hospitals and prisons for the management and treatment of men whose risk of serious offending was linked to severe personality disorder. The formerly named Dangerous and Severe Personality (DSPD) Programme brought together the Ministry of Justice (originally part of the Home Office), the Department of Health, Her Majesty's Prison Service and the National Health Service to deliver new mental health services for people who are, or have previously been considered dangerous as a result of a severe personality disorder(s). The aims of the DSPD programme, as set out in the Dangerous and Severe Personality Disorder (DSPD) High Secure Services for Men Planning and Delivery Guide (2008) are:

- better public protection
- provision of new assessment and treatment services improving mental health outcomes and reducing risk
- better understanding of what works in the assessment and treatment of those whose severe personality disorder presents a high risk of serious offending

Four units were set up, each capable of housing approximately seventy male patients/prisoners: in (Site 1) and (Site 2) high-secure hospitals, and in (Site 3) and (Site 4) high-secure prisons. Of the four original sites, only the two prison service units continue to provide treatment services. The decision was made to shut the hospital sites after an evaluation found that there was a "

significant difference in cost between" between the hospital and prison based services, and it was felt that " the prison units were better placed to provide the right context for treatment delivery and with a lower ratio of staff to prisoners Response to the Offender Personality Disorder Consultation (Department of Health, Ministry of Justice, 2011). The units at (Site 3) and (Site 4) now form part of the wider national Offender Personality Disorder Pathway which intends to take responsibility for the assessment, treatment and management of offenders who have some level of personality disorder (Joseph & Benefield, 2012).

X unit Personality Disorder Treatment Services

In order to be admitted for treatment on to The X unit, an offender must meet the following criteria:

- More likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover;
- Has a severe disorder personality disorder, and
- A link can be demonstrated between the disorder and the risk of reoffending.

Criteria for severe personality disorder will have been met if the individual has:

- A high psychopathy score as measured by Hare's Psychopathy Checklist – Revised (PCL-R) (Hare, 2003)
- A medium psychopathy score on the PCL-R plus at least one other Personality Disorder

- Two or more other personality disorder diagnoses

Treating Personality Disordered Offenders

Personality disorders are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. They fall within ten distinct types, categorised into three clusters based on their typical characteristics (the clusters do not include Psychopathy, although this is still considered to be a personality disorder). Figure 1 shows the Personality Disorders as classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This is the standard classification of mental disorders used by mental health professionals.

Figure 1: Classification and Characteristics of Personality Disorders

Cluster A (odd or eccentric disorders)

- Paranoid Personality Disorder

Characterised by an exaggerated sensitivity to rejection, resentfulness and distrust. Neutral and

friendly acts of others are often misinterpreted as being hostile or harmful.

- Schizoid Personality Disorder

Characterised by a lack of interest in interpersonal relationships, preference for a solitary lifestyle, secrecy, and emotional coldness.

- Schizotypal Personality Disorder

Characterised by a need for social isolation, unusual behaviour and unconventional beliefs such as a belief in magic or extra sensory abilities.

Cluster B (Dramatic, emotional or erratic disorders)

- Antisocial Personality Disorder

Characterised by a disregard for social rules, norms and cultural codes, as well as impulsive behaviour and indifference to the rights and feelings of others.

- Borderline Personality Disorder

Characterised by emotional instability, rigid thinking and chaotic relationships. Also includes instability in mood, interpersonal relationships, self-image, identity and

behaviour.

- Histrionic Personality Disorder

Characterised by a pervasive and excessive pattern of emotionality and attention-seeking behaviour.

Cluster C (Anxious or fearful disorders)

- Avoidant Personality Disorder

Characterised by a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.

- Dependent Personality

Disorder

Characterised by a pervasive psychological dependence on other people to aid decision making and provide reassurance. These individuals are lively, dramatic, enthusiastic and flirtatious. They may be inappropriately sexually provocative, express emotions with an impressionistic style, and be easily influenced by others.

- Obsessive-Compulsive Personality Disorder

Characterised by a general psychological inflexibility, rigid conformity to rules and procedures,

	perfectionism, moral code, and/or excessive orderliness.
Psychopathy / Psychopathic Personality Disorder	Characterised by enduring dissocial orantisocialbehaviour, a diminished capacity forempathyorremorse, and poorbehavioural controlsor fearless dominance.

As is demonstrated above, each personality disorder is associated with different types of problematic thinking styles and behaviours, some of which have been shown to impact on the extent to which someone can meaningfully engage with, and benefit from treatment. These are known as Treatment Interfering Behaviours (TIB's) or Responsivity issues. It is these problematic aspects of functioning which have contributed to this population previously being considered " untreatable" insofar as mainstream Offending Behaviour programmes are concerned(Salekin, Worley & Grimes, (2010). It should be noted that these behaviours are not necessarily treatment needs in themselves, but aspects of an offender's behaviour which if left

unmanaged, could create a barrier to the participant effectively engaging in treatment.

Management Strategies for Working with PD offenders

Hemphill and Hart (2002) state that " Treatment providers should devote attention to developing interventions that take into account the unique motivational strengths and deficits of psychopathic offenders", and this was an ethos that the team responsible for the development of the regime at the X unit strongly adhered to. Indeed time was taken to ensure that not just the formal treatment aspect of the X Unit, but also the regime to run alongside formal treatment was designed with the specific needs of a personality disordered population in mind. The following regimes and management strategies were designed to help offenders manage their own individual responsivity needs, with a view to motivating and encouraging them to actively participate in treatment designed to reduce their risk of re-offending.

The Conditions of Success / Strategy of Choice

The regime at the X Unit is based on strategies which are designed to structure prisoners' expectations and set boundaries. The Conditions of Success are: To participate constructively within the regime; Keep an open channel of communication; and be respectful at all times. The Strategy of Choices is a technique which " uses psychopathic offenders need for control and choice as a way of promoting self-responsibility and self-management" (Hemphill & Hart, 2002). The Strategy challenges offenders to see treatment as an " enhancement rather than a restriction" and demands that they make

a conscious choice whether to participate and accept The Conditions of Success, or not to accept them and thereby make the decision not to participate. Harris et al., (2005) describe the central message of the strategy as being “ we can’t make you change, and we don’t intend to try. But if you are willing to learn we can teach you how to change”. In this way, participants are encouraged to take responsibility for their own placement and success within treatment by being given the choice of whether to engage and adhere to the Conditions of Success or to be seen to be deselecting themselves.

The complimentary regime

Prior to a prisoner being assessed for suitability within X Personality Disorder Treatment Services, there is a period of assimilation onto the unit which is known as the ‘ Living Phase’. This phase lasts between approximately 6-12 months, and it is during this time that prisoners have a chance to get to know staff and become more familiar with the unit and its regime prior to their assessment taking place. Given what we know about personality disordered offenders having a tendency to get bored easily and to engage in sensation seeking behaviour as a result, it is important to avoid drop outs at this stage and that there is ample opportunity for prisoners to remain occupied. The complimentary regime was therefore designed to run alongside formal assessment and treatment sessions, and to contribute to the therapeutic environment on the unit. The core day on the X Unit is divided into four hour long sessions, three in the morning and two in the afternoon. This is again to accommodate the short attention spans of personality disordered prisoners. In addition to this, all staff/prisoner contact

is delivered on a 2: 1 basis; this is to guard against the conditioning and manipulation of staff, and to protect them against potential false allegations of improper behaviour. There is an expectation that prisoners will participate in the complimentary regime and are encouraged to choose a variety of activities. Prisoners are encouraged to interact with staff and other prisoners, again contributing to the therapeutic environment.

Treatment Programmes

In order to accommodate the complex needs of personality disordered offenders, treatment programmes on the X Unit were based on the ‘ What Works’ literature (Mcguire, 2001) but were designed specifically with the responsivity of PD offenders in mind. Formal treatment programmes are based on the principles of Cognitive Behavioural Therapy and delivered in both a group and on an individual basis. Noteworthy is the reduced group sizes (maximum 5) in comparison with mainstream Offending Behaviour programmes. This is in order to better accommodate and manage specific responsivity issues, and to encourage better group dynamics. Some of the treatment components on the X Unit form part of the Chromis programme (see Tew & Atkinson, 2013). The Chromis programme was developed specifically to meet the needs of psychopathic offenders and their response to treatment, for example becoming bored and disinterested in treatment, seeing no reason to change or failing to adhere to the boundaries of treatment (Tew & Atkinson, 2013). The programme asks that participants be open to learning new skills, it does not aim to change the goals of participants, but rather, modify the way in which they achieve them (Tew,

2012). Other treatment programmes have subsequently been developed in-house by clinicians.

Staff selection

Staff of all grades and disciplines are actively involved in the development and implementation of the clinical framework and there is an expectation that all staff contribute to the therapeutic environment regardless of whether or not they deliver treatment. Currently, operational staff must express an interest in working on the unit, and must undertake an interview to assess their suitability. All staff regardless of grade then undertake a development centre which is designed to assess four different competencies: Problem Solving, Team Playing and Networking, Communicating Clearly and Analytical Skills. Staff are then given recommendations for which roles they would suit best on the unit, and a skills development plan. However as stated I have been commissioned to undertake a review of this process and in order to do this, need to have an understanding of what types of qualities are needed to work with this population.

The importance of recruiting the right staff

Relationships with staff can impact on someone's motivation to engage in treatment.

Stuff on attachments

What the literature tells us – what the population want

Amanda's stuff

The impact of this type of population on staff

Foxy's stuff – resilience / emotional detachment

Key qualities that need to be assessed for in the new process

framework

References

American Psychiatric Association, (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed) DSM-IV. Washington DC: American Psychiatric Press Inc.

Department of Health and Ministry of Justice. (2011). Response to the Offender Personality Disorder Consultation.

DSPD Programme. (2008). Dangerous and Severe Personality Disorder (DSPD) High Secure Services for Men: Planning and Delivery Guide.

Harris, D., Attrill, G., & Bush, J. (2005). Using choice as an aid to engagement and risk management with violent psychopathic offenders. *Issues in Forensic Psychology, 5,* 144-151.

Hemphill, J. F., & Hart, S. D. (2002). Motivating the unmotivated: Psychopathy, treatment, and change. I M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 193-219).

Joseph, N. & Benefield, N. (2012). A joint offender personality disorder pathway strategy; An outline summary. *Criminal Behaviour and Mental Health, 22* (3), 157-232

Kielhofner, G. (2002). A model of human occupation: Theory and application. Lippincott Williams & Wilkins.

McGuire, J (2001). What works in correctional intervention? Evidence and practical implication. In G. A. Bernfield, D. P. Farrington & A. W. Leschied, (Eds.), Offender Rehabilitation in Practice: Implementing and evaluating effective programmes (pp. 25 – 44). Chichester: Wiley.

Salekin, R. T., & Worley, C., & Grimes, R. D. (2010). Treatment of psychopathy: A review and brief introduction to the mental model approach for psychopathy. *Behavioural Sciences & the Law, 28* (2) 10. 1002/bsl. 928

Tew, J. (2012). Chromis: Not just a fish. *Forensic Update, 105.* 25-28

Tew, J & Atkinson, R. (2013). The Chromis programme; from conception to evaluation. *Psychology Crime & Law, 19* (5-6), 415 – 431.